Notice of Independent Review Decision

Date notice sent to all parties: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
X

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is a Medical Doctor who is board certified in Anesthesiology.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld	(Agree)
☐ Overturned	(Disagree)
☐ Partially Overturned	(Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
Records were received and reviewed from the following parties: X, X, MD, and X

These records consist of the following (duplicate records are only listed from one source): Records reviewed from X:
X:
Denial Letters-X
LHL009-X
X XX XX / X XX XX /X, MD:
Utilization Management Prior Authorization Requests-X
Office Visit Notes-X
Letter of Medical Necessity-X
X
X Report-XX

Records reviewed from X MD:

X XX XX / X XX XX /X, MD:
Office Visit Note-X

Records reviewed fromX:
X:
Email chain-X

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a X year old X with a history of an X from X. The mechanism of injury is detailed as the patient was taking X X out of an X X while on a X and was X by another X. As X reached for the X in X of X to X X, X caught X X with X. Diagnoses included X of the muscle X of X of X, X X of X X. Progress note dated X indicated the patient had undergone X treatments including X with X, as well as medication management to include X and X. The patient continued to complain of X pain which was X. Clinical documentation indicated an X of the X X indicated X, X, X indenting on the anterior X and just approximating the X of the X without compression or significant X or X.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Though the patient had X pain that is X and has exhausted X treatment without benefit, there is concern that X may negate the results of diagnostic X and should only be given in cases of X. As there was no documentation the patient had significant X to warrant the X, this request is non-certified. Per evidence-based guidelines, and the records submitted, this request is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

☐ **INTERQUAL CRITERIA**

☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**